STATE OF LOUISIANA
WORKERS' COMPENSATION SECOND INJURY BOARD
POST OFFICE BOX 44187
BATON ROUGE, LOUISIANA 70804-4187
(225) 342-7866
Fax (225) 219-5968

NOTICE OF CLAIM WITH SECOND INJURY FUND

CLAIM NUMBER:	**DATE OF ACCIDENT:**	**DATE OF NOTICE:**

INJURED EMPLOYEE	**SOCIAL SECURITY NUMBER**
NAME OF EMPLOYER	**DATE OF FIRST PAYMENT OF COMPENSATION:**
NAME OF SELF-INSURED/CARRIER	**DATE OF FIRST PAYMENT OF MEDICAL:**

NAME OF THIRD PARTY HANDLER (IF APPLICABLE)
DETAILS OF PRE-EXISTING CONDITION (DATE, MEDICAL REPORTS)
DETAILS OF SUBSEQUENT INJURY: **(WC-1007, WC-1002, MEDICAL REPORTS KNOWLEDGE STATEMENT)**
REMARKS:

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SIGNATURE_____
CARRIER/SELF-INSURED_____
ADDRESS_____
CITY_____
PHONE_____

NOTE: **A NOTICE OF CLAIM MUST BE FILED WITH THE SECOND INJURY BOARD WITHIN 52 WEEKS AFTER THE FIRST PAYMENT OF ANY INDEMNITY OR MEDICAL BENEFITS PAID IN ACCORDANCE WITH THE ACT.**

SIB Form A